Death and Dying Done Well:

A Theological Reflection on Bioethics and Christian Theology

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May 2008

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A Word

He came into the world the way he lived and the way he died – gently and with great compassion. Jeremy let me know one March evening in 1972 that he thought it might be time to see the world. He didn't press the matter, he just waited. He let me sleep through the night until he was ready to join this complex and complicated life. Then he just appeared – no fanfare, no squalling, just Jeremy. Long and slim that day, he remained so, which over time was just one way he stood out in the world. Gentle and compassionate were words often used by his friends to tell of their love and admiration for this man. He was an artist, a drummer, a guitarist; and he was a steadfast and loyal friend to one and all, always advocating for those whose lives were less bright than his. He laughed easily and was a frightful tease. He loved life, Jeremy did – and he was gone from this world much too soon.

Jeremy's life was complicated – diagnosed with severe hemophilia when he was just three months old, our family routine became what we called normal: some kids have lots of colds in the winter, he had bleeds. Transfusion after transfusion for joint bleeds compromised his knees and elbows so badly that he became ever more crippled. Fine medical care by pediatric hematologists and orthopedists who understood the child-becoming-young man was always at our fingertips. I was trained to give him prophylactic transfusions when he was not much more than a baby; and by nine, he was mature enough to give himself the injections. He was free, independent, and was on his way to being responsible for his own well-being. We made decisions that would give him as much of a good life as possible – he played soccer with a transfusion administered before every practice and every game. He played pickup basketball the same way, although he would often defy the odds and go out without a transfusion! He walked to school as a kid, and had a car at sixteen. Jeremy was not going to be different, if he could help it. And I supported his independence, his decision to live life full out (and indeed, *he* decided, make no mistake about that!). What a joy it was to be his mother and watch him become someone who stood for so much. I was blessed, truly blessed. This was indeed a good life.

Sometime in his teens Jeremy was diagnosed with HIV, the result of tainted blood, the life force that had made his life so manageable, so hopeful. In those days this diagnosis was a death sentence – ten years maximum, the oncologist and hematologist told us. We'll put him on every protocol possible to help him maintain a good quality of life. "But make no mistake about it," they tried to kindly tell him, "your life will change. Dramatically."

And there was no question about it, his burden was mine, as well. The families of those who have catastrophic illnesses are not immune from pain and fear. We are not able to live in a cocoon, outside the circle of sorrow that suddenly appears in our lives. We

simply must learn to see the hope and joy that our loved one offers us – and learn to live with the rest.

A young man who went to college and received a degree in fine arts, Jeremy grew more and more compromised physically and spiritually. His good humor and bright outlook on life began to fail him, as his body did, and as his mother I could only stand by and watch helplessly. Over time his fragile health gave way to enormous medical issues requiring two major surgeries and even greater dependence on the pharmacological protocols that were designed to stave off the unthinkable – progression to full-blown AIDS and a horrible death.

Jeremy was wise enough and kind enough to think about the toll his dying would take on me. He had seen me work as a chaplain in a hospital and heard me talk about families and patients who are unable to come to terms with what it means to die, to leave this life in a way that honors the way they lived. I talked a lot about advanced directives and living wills, and when I had them executed for myself, he did, too. Jeremy stated clearly what his wishes were regarding his care and the continuation of life. Little did I know that soon his living will would have to be invoked.

Although death was not imminent, not by half, Jeremy did it his way, as he always had – living a normal life with good friends and a family who loved him. Going home after a celebration for one of his friends who had just taken a new job, a one-car accident rendered his life unsalvageable. Unconscious to the end and surrounded by the doctors who had cared for him for quite some time, by clergy who loved us both, and by "mom," he died peacefully.

Strangely, the decision to remove life-support was perhaps the easiest thing I ever had to do as a mother. Jeremy had clearly and with courage, foresight, and understanding made the ultimate decision for himself – he did not want extraordinary measures done if there was little or no hope of a successful outcome. He did not want any of the horrific possibilities to burden himself or me, for the sake of a selfish act of denial about reality. While the horror of having to let my son die was enormous and I grieve the decision even today, it was the right thing to do. His autonomy, his self-knowledge, and his strong sense of compassionate justice make me as proud of him today, as it did that morning seven days before I was ordained.

Jeremy died a good death because he lived a good life.

Does my devotion to an awe-inspiring God make me blind to the sacrifice Jeremy made to die, or that I made in invoking the decision he had made for himself? Not at all. For God is a loving God, who welcomes all who have been baptized in his name into his greater Presence – whenever that time comes, however it comes. And that is what informs and inhabits the theological framework in this paper.

Death and Dying

It is difficult for us to acknowledge that one day we will die. In earlier times, paintings sometimes showed ordinary men and women going about their daily lives pursued by a skeleton tugging at their coat or tapping them on their shoulder – the figure of death. This skeleton was part of their everyday life, a reminder that death was inevitable. Today, in contrast, many of us go about our lives pretending that we will never die. No figure of death seems to stalk us.

Yet no matter how hard we try to avoid thinking about it, there are moments that remind us that one day we will face death. This knowledge is background music playing faintly in the distance of our lives. It swells in volume and tempo when we or those close to us become seriously ill. At those times, death becomes more of a reality for us, especially if we must make decisions about whether to use powerful medical technologies to prolong our own lives or of those dear to us.

Modern medicine has developed the capacity to keep us alive much longer than was possible in previous generations. Such measures as respirators, feeding tubes, and cardiopulmonary resuscitation have improved the chances that those who are in fundamentally good health will survive an accident, heart attack, or stroke. But these remarkable medical technologies may only prolong the period of dying for those with multiple maladies who suffer such events. Indeed, they may even make it difficult for us to figure out that someone is dying at all, because they can keep people alive in the advanced stages of diseases that have no clearly defined terminal phase, such as Alzheimer's disease or COPD. In such circumstances, we must decide whether to use all available life-sustaining treatments or not, knowing that our decision will affect when and how we and those we love will die. We are among the first generations to have to make these painful choices. And we should not gloss over the truth that, even when a medical intervention offers little hope of benefit or cure, it is painfully difficult for us to forgo using it and allow the skeletal figure of death to enter our lives.

So many questions. Are there circumstances or conditions under which we would choose not to be resuscitated? Will antibiotics prolong our life and allow us to gain some joy and feel some purpose to it – or will they only extend our dying? How well can our pain be managed? Has a relative, who cannot speak for herself at this point, made out an advanced directive to give us a sense of what she would want done? If it is time to let our son go, like I did with Jeremy, how can we help him have a good Christian death?

Jeremy Taylor, the seventeenth-century Anglican moralist, declared in *Holy Dying*, "It is a great arte to dye well." He emphasized that a good death involves not only hope and reconciliation at life's end, but a good Christian life. We should not prepare for death just before it arrives but over the course of an entire lifetime. Taylor recalled that the 1662 *Book of Common Prayer* declared in its Burial Service that "none of us liveth to himself and no man dieth to himself." He painted a picture of the person near death surrounded by family, friends, and ministers of the church.

During the long night of vigil with Jeremy, waiting for the inevitable, I recalled Taylor's words and the picture they painted for me, and I knew that Jeremy was held in love and prayers by people who gave themselves unselfishly to be with him – and with me.

When we envision the death we want today, our picture is often not that much different. For many, a good death is a peaceful one in which we die easily and naturally, without discomfort, at home and surrounded by those we love. We share memories, become reconciled with one another, experience spiritual healing, and affirm our trust in the goodness and mercy of God. We close our accounts and finish our business in this life. A good Christian death, as the Anglican *Book of Common Prayer* declares, offers comfort, forgiveness, grace, strength, joy, and light.

Yet many of us are afraid we will not have such a death. When we picture the death we want to avoid, we see medical technology and pharmacological advances extending our lives while we linger semiconscious in a sterile environment, perhaps in unrelieved pain and suffering. No family, friends, or ministers accompany us to the valley of the shadow of death. Abandoned, we fall into despair and depression. The hope for faith, strength, mercy, and joy is absent from this vision of a bad death. It is a death we pray deeply to avoid

The Anglican Understanding of the Ethical Life

The moral issues that come to light as we seek a good death in the face of today's medical capabilities are so new and so complex that it is difficult to find one approach to them on which all Christians agree. Yet there is a framework of central Christian ethical teachings that sets limits to the differences that Christians may have. The faith of the Anglican Communion as lived through the Episcopal Church of the United States, on which this position paper is based, is grounded on scripture, tradition, and reason, and is nourished in a sacramental structure of worship. Anglicans/Episcopalians, following the teachings of the early theologian Richard Hooker, regard Holy Scripture as God's word addressed to human reason. It provides witness to the events that lie at the heart of the Christian faith and an interpretation of how a life based on that faith is lived. Anglicans believe that scripture has the capacity to awaken our reflection on God's purposes, as well as to elucidate God's relation to humankind and all creation. Nevertheless, Anglicans find throughout the Bible fundamental moral principles.

Tradition offers the accumulated and growing wisdom of the church. It amounts to a living presence of discernment. So, when Anglicans appeal to tradition, it's not to say, "We've always done it that way," but to affirm that the church exists over time. It is to say that Anglicans value the wisdom that realizes the way our discernment of the Biblical messages is guided by the Holy Spirit.

Through this discernment, Anglicans call on human beings to use the full powers of our God-given reason. Anselm, an eleventh-century archbishop of Canterbury, wrote of faith seeking understanding. Like him, modern Anglicans see reason as an aid to faithful Christian belief and conduct. Accordingly, reason is not simply intellectual analysis and

acuity, but is also reflection on human feeling and experience; in other words, using our fullness as human beings to discern the sense or presence of God.

Anglican moralists have tried to embrace many traditional Christian moral principles and distinctions. Yet there is no single method by which Anglicans move from these principles and from the three sources of moral authority – Scripture, tradition, and reason – to resolve moral questions in specific cases. Thus, deeply faithful members of the church have, at times, reached conflicting conclusions about specific questions because they have moved in different ways from principles to their application to issues. To complicate these conclusions further, the church itself has changed its positions over time on important moral issues as it has reworked the way in which it applies moral principles and its three major moral resources. Anglicans have discovered that morality – the ethical life -- cannot be reduced to a single abstract formula, but must deal with life in all its concreteness and multiplicity.

Anglicanism has embraced a moral vision that displays several distinctive features, namely,

- A conviction that a moral order founded on God's wisdom pervades creation.
- A belief that it is essential to our relation to God to live a moral life, for in God "we live and move and have our being."
- A recognition that the moral life is not narrowly defined by the desires, attitudes, and intentions of individuals, but that it has a social dimension rooted in our communion in the body of Christ, and
- A commitment to the values of love and justice, based on the beliefs that creation is good and that each person, as a creature made in the image of God, has unique worth.

Given the openness of this basic moral vision and the varying ways in which persons move from principles and resources to their application to issues, it is not surprising to find that different Anglicans and different branches of Anglicanism sometimes express divergent views on ethical issues. The Anglican tradition has a commitment to respect the differing views and positions that faithful people might reach on difficult moral issues.

Given the previous overview of Anglican moral theology, the question arises: Is there an Anglican view of death and dying? Yes.

Anglicans neither minimize death's finality nor deny the grief and pain that normally accompany it. Anglicans perform funerals with a closed coffin and throw dirt, that is, real soil, in their interment service. Their funeral service does not discourage mourning and grief, quite the contrary. However, it offers consolation and love to all who cast their grief on God. This is because the Anglican understanding of death and dying is grounded in Christian beliefs about the Incarnation, that is, God becoming fully human in Jesus Christ, and about Jesus' resurrection from the dead.

The popular Anglican Christmas carol "Once in royal David's city" sings of a Christ who both "shareth in our gladness" and "felleth for our sadness." This expresses our belief that God is manifest in the fullness of our humanity, that God was among us as a complete human being in Jesus. In this full humanity – in his living and dying – Jesus

reveals and reconciles us to God. Christians believe that by Christ's free acceptance of death, in obedience to the Father and for our sake, God has broken the power of death to claim the last work over our lives. When Jesus accepted death as part of his vocation to obey God and serve humanity, he transformed death into a breaking in on the divine presence.

The Christian church, including the Anglican church, therefore, teaches that all should enter death in Christ, that is, to look upon their dying as a journey with Christ through death into the fullness of life in God. Death, while retaining its dreadful and enigmatic powers, becomes, through faith, an opening up to coming into the presence of God. Jeremy was no less in God's loving care and mercy while he was living. But he moved into a new realm, a new way of being with God, because he chose to die with Christ through his baptism. Because of the efficacy of our baptism, Anglicans do not view death as an enemy outside of themselves capable of destroying all meaning in their lives. Rather, Anglicans believe that death, while still a terrible reality, is an enemy God has taken into his own life through Christ and overcome it in him. Anglicans believe that they can move through death and resurrection into God's life.

Thus, the wider question for purposes of understanding the moral issues about end-of-life treatment is this: Is it possible for Christians to share core beliefs about creation and death, and yet reach different conclusions about treatment at the juncture of the secular medical world and the sacred theological one?

Christian Vision in Bioethics

Although the best work in bioethics has involved the application of certain ethical principles to particular issues of clinical concern, such as respect for autonomy, beneficence/maleficence, and justice, there is no way to apply such principles in a vacuum. Bioethics strives to generate moral insight and offer practical guidance in relevant areas, ranging from the care of individual patients to the development of social policy. In pursuing its goals, bioethics champions a central human question: "What are my duties and obligations to other individuals whose life and well-being may be affected by my actions?" Operating in close proximity, bioethics and religion are essentially kindred, because they both make normative claims regarding fundamental human values and the way these values are weighed and acted upon. All ethics is concerned with that which is moral, thus ethics, including bioethics, is framed by the parameters set by the actual, by reality. While some conflict is inevitable, this tension does not rule out productive interplay. In short, then, bioethics and religion best serve the common moral life when they challenge each other's tendency to engage in arrogant, absolutist posturing.

How Christians understand the question above, and how we understand the medical situations we encounter, depends upon background beliefs that we bring to moral reflection – beliefs about the meaning of human life, the significance of suffering and dying, and the ultimate context in which to understand our being and our doing. Our views are shaped by reasoned argument commonly held at a kind of prearticulate level. We take them in with the air we breathe, drink them in from the surrounding culture. Therefore, it is useful to remind ourselves as Christians of how contrary to the

assumptions of our culture the Christian vision of creation and death may be, especially as it relates to autonomy, disease and healing, and justice.

Bioethics talk is often talk about rights. Such talk is absolutely essential in many contexts. To ignore it is to ignore the just claims of others upon our attention and our care. But for Christians the relation of individual and community is too complex to be dealt with such language alone. To wit,

In baptism we are handed over to God and become members of the Body of Christ. That is language about community yet, perhaps paradoxically, the first thing to note about baptism is that it is a deeply individualistic act. Our achievement of individuality is not a personal one, and, most strikingly of all, it is established only in community with God. To the whole extent of our being, we belong only to God, whom we must learn to love even more than we love anyone else in our lives. If the first thing to say about baptism is that it establishes our individual identity, we must immediately add that it brings us into the community of the church, of the faithful – with all those whom God has called by name. It is utterly impossible to exist in relation to God apart from such a bond with all others who have been baptized into Christ's Body. We are called to bear their burdens as they are called to bear ours. Sometimes we are reluctant to do so. At least as often, we are reluctant to have them bear ours so eager are we to be masterful and independent.

If baptism is the sacrament of initiation into Christian life, it should also inform our understanding of individualism. Christian theology does not suppose that any individual's dignity can be satisfactorily described by the language of autonomy alone – as if we were most fully human when we acted on our own, chose the course of our life plan, or were capable and powerful enough to burden no one.

That said, there will still remain, and should remain, a place within the political realm for the language of independent individualism. Christians should recognize that, in a world disturbed by sin, great evil can be done in the name of community. Because sin distorts every human relationship, because, in particular, it leads the powerful to abuse and diminish the weak and voiceless in the name of high ideals or the common good, every individual's dignity must be protected.

In the second book of *Chronicles* we read of Asa, one of the kings of Judah. Not surprisingly, his reign was a mix of good and bad, but, in the eyes of the Chronicler, it ended badly. After looting the temple treasure to forge an alliance with Syria in time of need for his kingdom and being denounced by the prophet Hanani for doing so, Asa became severely ill; "yet," writes the Chronicler, "even in his disease he did not seek the Lord, but sought help from physicians." Shortly thereafter he died. The Chronicler's point is clear, but it is difficult to understand. Its clarity lies in the starkness with which we are required to ask whether the measures we take to secure ourselves reflect a lack of trust and confidence in God. Its difficulty for Christians, however, lies in the Chronicler's suggestion that God's defending and healing work is always of his own volition, never to be mediated through the work of human beings.

In Jeremy's life (and mine) he would have argued against the Chronicler's proposition: that healing is either from God or from doctors. Jeremy's whole life was lived in the midst of the holy and the secular, combining graces and mercies emanating from

both for the good of God's beloved servant. This posits the question, unanswerable though it is: What if Asa had invoked both God and physicians?

The warning and the disturbing thoughts that arise from Asa's departure from the God he served alerts us not to ask of medicine more than it can offer. Through doctors and other important care providers, God often treats our disease, sometimes even our more general feeling that we are not well, are not whole, although we may have no identifiable disease. But doctors are not saviors, nor are nurses, pharmacists, even chaplains, and the best clinical specialists know that, even if they only think of themselves as cooperating with the powers of nature and science – or as being present with those who are ill as someone with whom to share the journey. These very dedicated professionals, however, may not always be able to heal our diseases, but, in accepting suffering and dependence as part of our personal history, we may be drawn closer to God – and so may they.

Christians need not fear that seeking medical help necessarily demonstrates lack of trust or faith on our part. Rather, it indicates only that we trust God to care for us as mediated by the love and concern of others. But at the same time we cannot suppose that medical caregivers can finally provide the wholeness we need. They stand beside us, but they have not voluntarily shared our fate. They are lordly and awesome in their technical prowess, but they are not the Lord whom death could not hold.

Bioethics is not just about the difficult moral problems that are encountered in the medical realm, nor is it only about decisions that must be made in one moment to another. More fundamentally, bioethics invites us to think about the way we live toward death in a world marked by suffering and illness. It should provide us an occasion to consider how our way of life is shaped by the fact that we trust in a God who suffers for our redemption.

In the ninth chapter of the *Gospel of John*, Jesus heals a man who has been blind from birth. Jesus' disciples, seeking an explanation for the man's blindness, ask, "Who sinned, this man or his parents, that he was born blind?" They assume, as Israelites of the time would ordinarily have assumed, that such blindness cannot have been entirely at random. Someone must be responsible for it. Jesus turns away from such a tight connection between sin and sickness. "It was not that this man sinned, or his parents," Jesus says, "but that the works of God might be made manifest in him."

This response makes us uncomfortable. On the one hand, it suggests that illness – who is and who is not – may be harder to fathom than the disciples thought. No connection between sin and sickness can be simply assumed. There should be no assumption that God is punishing the sick person, singling him/her out for retribution. However, it seems to say that the man's blindness, indeed all sickness, is by no means a random occurrence. Does it say that it is the providence of God at work in the man's blindness, fashioning the opportunity for Jesus to work a great "sign" by healing him or those who are part of the community that surrounds him, including the disciples? Perhaps all we can conclude is that the reasons for sickness may often be beyond our understanding. Jesus does not say that sin never results in sickness, nor does he say it always does. He does not say that sickness never strikes at random without apparent reason, only that it did not in the case of the man he healed. Jesus leaves us on our own

to puzzle over this question – with the clear warning, however, that our ways are not God's, and his purposes may be beyond our comprehension. But Jesus does say one thing more. He gives the sufferer the dignity of being united with his own suffering, and he gives us today the duty of attending to the sick, directing and freeing us to show compassion to all who are ill. It is to give theological voice in a world dominated by modernity, even though the Enlightenment has long since passed.

Biblically, theologically and morally, the voice of the Christian is to insist on the onus of judgment and mercy. Laurie Zoloth would say that bioethics is about "living within the tension between freedom and command, duty and choices – not simply about the resolution." This seems obvious, but it has bearing on the expectation that religiously informed bioethicists, in the sense of understanding the normative beliefs that inhabit the lives of all people, bear also the pastoral tasks within the clinical context. The converse is equally true for those who are not strictly speaking bioethicists but who work in the realm of understanding existential anguish brought about by illness.

Conclusion: Article of Faith

The following quote from the Jewish philosopher and theologian Martin Buber has enlivened the beginnings of thoughts and conclusions that arise from this paper:

"I have occasionally described my standpoint to my friends as the 'narrow ridge.' I wanted by this to express that I did not rest on the broad upland of a system that includes a series of sure statements about the absolute, but on a narrow rocky ridge between the gulfs where there is no sureness of expressible knowledge, but the certainty of meeting what remains undisclosed."

This exploration of the intersection of bioethics and Christian theology has been like a good talk with a few good friends or, better yet, a long walk with them on the narrow ridge that Buber speaks of. It is a walk between and among everything that we know and everything we do not know – all the visions, sacrifices, and the blood; the lives cut in half and then put back together – counting on the not-knowing to be a blaze of stars leading the way. Bioethics is not just about the big choices at the crossroads, but about how to live decently always, as though that would be enough. It is also about the stories of the communities we live in and those arising from the texts ancient and modern that we re-live through our imaginations. This larger narrative offers an ultimately trustworthy hope for order, that is to say, the possibilities of a language to convey deeper meaning, the probabilities that compassion will arise out of the call of Christian baptism, and the deep and persistent yearning for justice that we believe inhabits the world.

Perhaps there is still the question to be asked of the place of religion in the field of bioethics. Can we theologians and scholars of religion make ourselves useful around the place? Can we add to the construction project of medicine and science by holding out in our cheerful, faithful way the clever tool to fix a problem? There may very well be a more intrinsic question to be asked, one that sets aside our need to control any outcome, one that gets to the heart of the matter: *How shall I live?* By this I mean: How is it that I (or you or we) can live, understanding that beneath the floor of our being – the decency of modernity, the technology and art used in caring for others, and most especially, the truth

claims of science and medicine – lies a dazzling Reality, only barely seen "through a glass darkly."

In consideration of this vision of the question, the American sociologist and Lutheran theologian Peter Berger uses the term *doppelbodigkeit,* a term derived from German theatre that refers to a stage with more than one floor. It implies that at any moment those who walk on it may fall through a trapdoor to a lower floor. Berger's argument in favor of the language of *doppelbodigkeit* as an agent of modernity has created in us a belief in the certainty of an ordinary and reasonable existence, while dismissing as absurd anything that points us toward or hints at the infinity, the totality of what surrounds us.

Nowhere is the totality stronger, or more necessary, than in the clinical world. It is in the clinical encounter, where both of the participants have, for a moment, fallen through the trapdoor in the floor – You will die, says one. I will die, say the other. It is here that we most yearn for a way out. We are good-hearted, well-trained professionals, and because we are, we proceed back up to the top floor; we get a grip; we talk of statistics and strategy; we understand the immanence of death; and we turn away from one another to the world of busy-ness. And our questions remain, still not intersecting: What is to be done? What is to be said?

Sickness, suffering, and death plague human life, and are often called evil. To a Christian that is not the greatest evil. The greatest evil would be to lose God, to have reason to doubt his faithfulness to us. We affirm that faithfulness, although we confess it might not have occurred to us had God not simply done it. God defeats and destroys the negative powers of sickness and death, but he does it by claiming even that realm as his own, by entering it and bearing it to its own logical end. The perfection and power of God is displayed in the acceptance of our neediness, dependence, and even suffering.

Buber hints at something more: the real terror of living and dying is not the darkness but the light, the extraordinary and fled-from that *might, after all, be real* – a Presence that could call one to give everything, a vastness of force that terrifies each of us. It is that falling, not from belief, the *doppelbodigkeit's* first floor down, but to the next one, that of deep belief. That is why we are so fearful. For seeing both the present reality of humanity and the largeness of infinity, and sensing the forces for justice and passion, we are called into the last task we know we will need to do in human life – to face with nobility our own death. And a bioethics informed by this vertigo and this struggle is indeed a changed bioethical terrain.

This need not nor should not mean a rejection of the powerful healing that scientific and clinical medicine has to offer us. The best physicians know, however, that their art at its highest must cooperate with powers beyond their own. We should give them our respect and gratitude, but not our devotion – and the best of them seek no more. Instead we place our ultimate hope for health and wholeness in our living and our dying in the God who himself has been broken by death – and who nevertheless lives.

Jeremy Taylor, the seventeenth-century Anglican moralist mentioned earlier, asked in *Holy Dying,* "And how, if you were to die yourself? You know you must. Only be ready for it by the preparation of a good life. And then it is the greatest good that ever happened to thee."

After Word

I have walked Buber's narrow ridge, sharing my life and values concerning living and dying with others who may or may not agree with me. I have been enriched by the conversations and by the unfinished business it continues to put before me. I write these reflections as a Christian for other Christians who want to think about these issues. They are aimed at those who name as Lord the God of Abraham, Isaac and Jacob and who believe that this Lord lived as one of us in Jesus of Nazareth. It is a matter of empirical fact that not all Christians agree with the propositions I articulate in this paper. (Nor do I believe that all bioethicists and physicians would agree with my claims.) I do not mean that I have taken a survey of the opinions that exist, nor have I written a history of their views. Rather, after a discussion of and research into the basic understandings of bioethics today, I have tried to say what we Christians ought to say in order to be faithful to that truth that has been claimed in Jesus Christ. The problems may often seem new and driven by technological advances, but the search for human wisdom and faithful insight requires of us a longer memory and a more expansive vision.

I owe an extraordinary debt to Dr. John Z. Sadler, Professor and Director of the Program in Ethics in Science and Medicine at University of Texas Southwestern Medical Center, Dallas. He listened to the questions in my soul about how we live and die and thought it might be a valuable experience for me to share part of my questioning with others at the medical school and at Parkland Hospital. He never promised answers, only more questions. He was generous with his time and his perspectives, and open to sharing this journey from the perspective of an Episcopal priest.

The Palliative Care Team at Parkland welcomed me to share clinical time with them and some of their patients, time for observing the particulars of ethical decision-making with those who are dying, and to begin framing those decisions in theological terms. Each of them not only gave of their expertise, but also very often their curiosity – why would a clergy person be interested in making sense of their callings in a non-medical way? My sojourn among them was sacred, and it was difficult to depart from there, for I felt then, and still do, that my work in this realm is unfinished. My deepest thanks to Dr. Elizabeth Paulk, Palliative Care Medical Director; Dr. Elizabeth McKinnis, Assistant Professor of Internal Medicine; Betsy Porter, RN and Nurse Practitioner; and Carol Chamberlain, Pharm.D and Pain Specialist, as well as the others on the team. The Rev. Linda Wilkerson and the Rev. Ross Prater created the logistical avenues so that I could be part of the Parkland System and, more importantly, Ross offered his considerable experience in palliative care graciously and with great integrity. I could not have done what I did without his assistance. Thank you, Ross.

This project began with a conversation with an old friend from palliative care days at another hospital, Dr. Michael Limerick. Michael was a respected colleague and trusted

friend who knew Jeremy and the effect his life and death have on my priestly vocation. He listened, encouraged me and sent me on my way to Dr. Sadler, believing that my passion for these issues would carry me beyond my lack of medical academic experience. I hope I didn't let you down, Michael.

Of course, there are others: those at the Episcopal Seminary of the Southwest, Austin, who mentored my writing and my journey – the Rev. Kathleen Russell, whose experience as an ethics consultant in a major hospital in Washington, DC, was paramount to my thinking; and the incomparable Rev. Charles Cook. It was through their generous offices that I was the recipient of a Visiting Fellowship so that I could pursue this project. They offered their experience and their friendship, and I shall always be grateful for both.

Mikail McIntosh-Doty has been extremely generous with her time and expertise in academic and theological writing. She took my initial words in this paper and asked me to consider telling Jeremy's story. She understood that his story deeply informed my passion for bioethics and its intersection with theology. If there is any truth in what I have written, it is in large measure because of her encouragement and her friendship. Many thanks, Mikail, and God bless your gifts.

Naturally, there are others who made this work possible. I'm especially grateful to my two bishops, the Rt. Rev. Larry Benfield and the Rt. Rev. Don Wimberly, for their interest in my continuing desire to have a full range of passions for my ministry. In ways that cannot be counted, the Rev. Canon Andrew Doyle has been particularly encouraging and supportive of my ministry in the Diocese of Texas.

Most of all, I simply offer myself to the Church as a servant of Christ, knowing that all that I am and all that I will be comes from devotion and commitment to my vocation as manifested in my ordination vows. I belong to God, I belong to the Church, and I belong to God's people, especially to Jeremy. Still. Even yet.

AMEN.